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CLINICAL OBSERVATIONS ON REFLEX GENITAL NEUROSES IN THE FEMALE.*

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IT is customary to ascribe the majority of nervous manifestations in the female sex to the fact that they occur in "women," and to assume that on the organs which particularly entitle them to their sex depend more or less directly the mental and nervous peculiarities so well known and so universally admired when healthfully displayed, and so feared and deprecated by the sterner sex when disordered or unduly exaggerated. But the old saying, "Propter uterum mulier est," is even less correct than to substitute "ovaria" for "uterum" since not even a combination of both "uterum" and "ovaria" fully covers the ground when we look for the organs, on the derangement of which the peculiar local and reflex neuroses which form the subject of this paper are based. Not only the uterus and ovaries, but also the bladder, rectum, vagina, clitoris, labia, perineum, and the now so fashionable Fallopian tubes, all join in producing local or reflex neuroses. To properly estimate the origin and importance of these neuroses is often as difficult as it is to avoid referring every

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distinct nervous disturbance in a woman to her sexual organs. No doubt many errors are made in this latter particular, since it is but natural for every specialist to seek to explain doubtful symptoms and complications on the general principle that all the rest of the body turns about the pivotal organs in which he is specially interested, and I do not think that the gynæcologist is any worse in this respect than the neurologist, or the dermatologist, or the other "ologists" too numerous to mention.

I may be permitted to say that, personally, I have endeavored to avoid straining the relations of cause and effect between distant neuroses and insignificant genital lesions as much as possible in my practice; and I know of a number of cases where I have refused to believe a general anæmia, or a hemicrania, or a neurasthenia, to be due to a hyper-plastic uterus, or a lacerated, but healed cervix, when some of my colleagues, who differed from me, have seen fit to use local treatment or sew up the cervical tear. But I can report, on the other hand, a fair number of cases in which it seemed to the highest degree improbable that the distant neurosis had any thing whatever to do with the genital lesion, and in which treatment and cure of the latter resulted in permanent relief of the former. Before briefly relating a few of these cases, I think it will be well to give a survey of the varieties and approximate causes of the genital neuroses most commonly met with in females.

Reflex neuroses may be divided into two main groups—physical and psychical:

1. *Physical*.—These may be again divided into *local* and *peripheral*.

Local neuroses occur in any of the various organs contained in the pelvic cavity or bordering on the genital cleft. Thus we find tenesmus of the neck of the bladder, generally due to exposure to cold, or an irritable bladder, requiring frequent evacuation, commonly met with in excitable women, or under some form of mental disturbance; or pruritus vulvæ, uncomplicated by diabetes or vulvitis; or a hyperæsthetic condition of the vaginal orifice producing the condition known as vaginismus; or a throbbing, lancinating

sensation in the vagina is complained of; or the woman speaks of experiencing motions in the hypogastric region similar to those of quickening, a symptom which I have generally found to be associated with subinvolution or hyperplasia of the uterus; or a numb, dull ache is felt over the sacro-ischiatic space, when I generally expect to find a congestion or adhesion of the corresponding ovary. One of the most frequent local neuroses is sacralgia, the well-known "back-ache," to which most of our present women are victims more or less; and while it is often due to a backward displacement of the uterus, I frequently find it present without being able to detect the slightest *direct* relation between it and the rectum, the pelvic cellular tissue, or the uterus, even though the latter organ may be in a pathological condition.

Pain in the ovarian region is also not uncommon with apparently perfectly healthy ovaries and tubes, and we are obliged to include in our list of sexual diseases the vague condition called "ovarian neuralgia"; I say vague, because the minute morbid changes which *may* produce the so-called neuralgic pain, are unrecognizable by our methods of exploration.

In calling these various sensations "neuroses" I wish to emphasize the fact that ordinarily they are unassociated, so far as physical examination can reveal, with organic disease of the organ where the sensation is experienced. Thus in sacralgia, the sacrum is not diseased; in vesical tenesmus, there is no organic disease of the bladder; in pruritus vulvæ, the mucous membrane and skin of the vulva are not pathological, except in so far as is caused secondarily by scratching. The peculiar sensation resembling quickening, which I believe to be a neurosis of the intestines, is produced probably by hyperperistalsis.

These neuroses are not necessarily acutely painful, but, like the frequent micturition and hyperperistalsis, merely annoying.

At times it may be difficult to differentiate and to draw the line where a neurosis ends, and a neuralgia or actual pain begins. The true distinction is that the *pain* is usually

situated in the diseased organ ; the *neurosis*, however, is reflex, no matter how near by.

Peripheral neuroses do not require the explanation just given. They are either unpleasant, annoying, or actually painful sensations experienced at greater or lesser distance, but entirely away from the genital organs.

One of the most common distinct reflex neuroses is hemicrania (migraine, sick headache), which is frequently limited to the menstrual epoch, but often comes on at irregular intervals in the intermenstrual period. It is by no means always dependent upon or associated with organic sexual disease, and hence is so often incurable. The so-called hot flushes over the face and neck are a familiar reflex neurosis. Cephalalgia, chiefly vertical and occipital pressure ; also frontal headache ; cardialgia, palpitation, and intermittent pulse ; gastralgia and dyspepsia (Fothergill has described an "ovarian dyspepsia" dependent on chronic oöphoritis and curable only through treatment of the latter) ; intercostal neuralgia, are other forms of reflex peripheral neuroses.

The oculists are familiar with the optic derangements so commonly met with in women during the menstrual period : the blurred vision, myopia, strabismus, occurring before menstruation or when the flow is scanty, and which are not always referable to retinal hyperæmia or faulty muscular attachment. The laryngologist need not be told of the aphonia which may accompany menstrual suppression, or of the hacking cough so often depending on uterine disease, and the neurologist is well aware of the relation between utero-ovarian disease and so-called spinal irritation and general neurasthenia. And who has not heard of the familiar globus hystericus, of which neurosis more anon ? Approaching the pelvis again, we find a very common annoying, if not painful, symptom to be the abdominal bloating of which many women complain just before their menstrual period, as well as at other times. This is not due to constipation, although such women are generally afflicted with that infirmity, but it is a reflex neurosis, the exact physical explanation of which has not always been quite clear to me ; I have thought it to be a temporary paresis of

the intestine, allowing it to fill with gas, but I could not gain from the patients the information that large quantities of gas escaped before they were relieved. Asafetida generally reduced the bloating, but it must have acted as an antispasmodic and nervine, rather than as a carminative. Sciatic and crural neuroses are not uncommon as the direct result of some disturbance of or pressure on the sacral or crural nerves within the pelvis. These neuroses so closely approach the character of actual pain, as to be more properly called neuralgiæ. Pelvic exudations usually produce the sciatic, and ovarian inflammation the crural neuralgia. These may extend down to the knee and even to the ankle.

These peripheral neuroses at times change in intensity in proportion to the local pain. Thus I have a patient at present with severe ovaralgia on the right side (at least I cannot detect any organic change in the ovary), and frequent frontal cephalalgia, in whom the ovarian pain and the headache often alternate, one increasing as the other abates.

Psychical Neuroses.—The variety of these is much less numerous than the physical. The most common and familiar form is that protean monster, hysteria, which may simulate almost any and every ailment to which flesh is heir to, from pregnancy to hip-disease, and from paralysis to pulmonary phthisis. It is not necessary for me to go into detail on this familiar topic; but I may say that, while a combination of phenomena presenting the peculiar features of hysteria but rarely occurs in the male sex, notwithstanding, hysteria by no means invariably proves the existence of or its dependence upon organic sexual disease. Hysteria is a functional disturbance of the cerebro-spinal system, occurring in highly-strung, excitable women, whose genital organs may be perfectly healthy. Hystero-epilepsy may also be considered a psychical reflex neurosis, since the epileptiform convulsions are merely a result of the reflex cerebral disturbance.

This neurosis is more frequently met with as the result of the imperfect performance or inception of the menstrual function, either from sluggishness of the circulation, de-

ficient innervation, or imperfect development of the ovaries or uterus.

The psychical neurosis which is most commonly met with toward the menopause is melancholia.

As cancer of the uterus is the physical rock on which so many women have been shipwrecked at that critical period of their lives, so is melancholia the mental danger which threatens them at the same time, and it does not necessarily follow that organic local disease must be the cause.

It may well be said that nearly all, if not all, the reflex physical neuroses enumerated above may present themselves in a woman during the longer or shorter period, extending from several months to several years, occupied by her transition from sexual activity to sexual senility. And generally they exceed in intensity the same symptoms earlier in life. Chief among these may be mentioned the abdominal distension, which often induces the firm belief that pregnancy is again present after a more or less prolonged interval; and the flushes of the face, alternating with chills. Vertigo, too, is a common neurosis, although it may depend on irregular circulation.

Rarely the cerebral functions may become impaired at the climacteric, and aphasia, dulness of intellect, and a tendency to incoherency in speech and thought may for a time alarm the friends. I have seen local lesions which at other times would be unattended by the slightest anxiety or worry, at that period produce mental depression requiring temporary seclusion in a retreat.

But I must not dilate too much on my theme, and will pass on to say a few words about the treatment. As I have already stated, it is not always easy to trace the relation between the local lesion and the neurosis; and good judgment, caution, and often, as much as any thing, honesty, are required not to extend the specialistic lines too far. But it goes almost without saying, that where a distinct local lesion exists, be it in the ovaries, tubes, uterus, perineum, bladder, pelvic peritoneum, or cellular tissue, it should be remedied to the best of our ability, even though we may not be able to trace distinctly the relation between the

local condition and the peripheral symptoms. And this indication may sometimes carry us farther than a logical sequence would lead us to go. Thus, if a woman with a moderately lacerated perineum or with one that is partly healed by cicatricial bands, shows symptoms of nervous irritability or melancholia, and we learn on careful inquiry that coition is no longer agreeable to her husband on account of the relaxed state of the vaginal orifice, or it is painful to her on account of the tender cicatrices, and she therefore shrinks from the act when her husband desires it, —then I think we are justified in proposing a restoration of the perineum to its integrity by an operation, although in itself the degree of the rent does not call for such treatment.

Again, if a patient has a distant reflex neurosis, the cause of which is obscure, which does not yield to treatment, and at the same time has a lacerated cervix or a retroverted uterus, which latter give her no inconvenience, we still should remedy these genital lesions on the principle that in the female sex it is well to remember that any functional disorder, no matter how remote its seat or how obscure the connection, *may* possibly depend on genital disease, and *may* be relieved by the cure of the latter. This is a safe rule if it is not overdone.

Besides the treatment and, as far as possible, cure of the local lesions, after which *immediate* relief should not always be expected, measures to improve the general health (tonics, phosphorus, iron, strychnia, etc., massage, "food and rest cure," general galvanization to spine and extremities), in "spinal irritation" and cerebral flushes, blisters between the shoulders, or the actual cautery along the spine, or the milder dry cups daily, should be adopted. Sexual abstinence is usually indicated. Each case should of course be treated on its own merits. I have seen much good result to the peripheral neurosis from vagino-abdominal galvanization continued for several months.

The usual routine of the antispasmodics (asafetida, valerian, Hoffmann's anodyne, etc.) is, of course, indicated; and the digestive and intestinal functions should be carefully attended to,

Improvement is usually slow to come, and relapses may occur. But where there was a distinct relation between the local lesion and the neurosis, a cure is most likely to be effected by the removal of the local cause.

I will give a few brief histories of several cases which have come under my observation, in order to illustrate the peculiar forms which the reflex genital neuroses may assume in the female sex.

CASE I.—*Hemicrania of eighteen years' standing; cured by operation on old laceration of cervix and pelveo-abdominal galvanization.*

Mrs. C. S., thirty-nine years of age; married twice; one child by first husband eighteen years ago; married seven years to second husband without conceiving. Complains of frequent pain in right groin and down right thigh, with right hemicrania, nausea, and vomiting, both of which symptoms are most marked before the menstrual flow. Examination showed a bilateral laceration of the cervix of the third degree, completely healed over; extending from the angle of the rent in the right side was a small, hard nodule, evidently an old plastic exudation, pressure on which caused pain down the right thigh. Basing on a previous good result from galvanism in acute sciatica due to pelvic exudation, but without expecting any benefit to the hemicrania, I applied galvanism by a vaginal electrode and a sponge over the right ovarian and sciatic regions, with the result of not only relieving the sciatica, but, curiously, also the hemicrania, the attacks of which diminished in frequency and severity after several weeks of galvanization, and finally ceased entirely. The cure was confirmed by excising the cicatricial tissue in the angle of the cervical tear and uniting the edges. The patient has since then (nearly five years) remained free from sciatica or hemicrania.

CASE II.—*Reflex cataleptiform syncope caused by pressure on the cicatrix of a lacerated cervix; trachelorrhaphy; cure.*

Mrs. H. B., twenty-two years old, mother of one child five years before, was brought to me in the autumn of 1881 by her husband, because since the birth of the child she had gradually lost all sexual appetite, and recently actually seemed to fall asleep during the act, of the performance and completion of which she seemed totally unconscious. On examination, I easily detected a deep laceration of the cervix, and pressing firmly into the angles of the rent, I asked the patient if I gave her pain. Receiving no reply, I looked at her face and found her fast asleep. Only deep pressure through the abdominal walls over the ovarian regions aroused her. Pressure on the cervical cicatrix at once reproduced the hypnosis.

Deep excision of the cicatrices and union of the surfaces effected a perfect cure.

Peculiar reflex neuroses from cervical lacerations have been reported by Sutton (epileptiform convulsions), Ill (loss of sexual desire and orgasm), myself (hemicrania), and I have a singular case to relate in which persistent chorea was apparently due to the same local lesion.

CASE III.—*Unilateral chorea, persisting for months after confinement, eventually cured by trachelorrhaphy.*

Mrs. F., a native of Alabama, was referred to me in 1881 by Dr. E. C. Seguin, who had in vain endeavored to relieve the choreic convulsions from which she had suffered for some time. He suspected possible uterine disease, and requested me to examine her. I found a well-marked retroversion of the uterus and a double laceration of moderate degree. I advised replacement and retention of the uterus as the first step, attaching more importance to this lesion than to the comparatively insignificant cervical laceration. This was done, but no relief to the chorea followed. The cervix was then operated on, and the first operation proving only a partial success, a second attempt was made to repair the rent, which was successful. But still the chorea continued; the patient eventually returned home, and I put the case down as a failure, especially as I had not held out any great hopes from the operation. Imagine my surprise to receive a visit some two years later from a Southern lady, who introduced herself by saying that she was sent me by Mrs. F. whom I had "cured" so skilfully, and who was now perfectly well.

I admit the element of doubt in this case, for time may have done as much as my treatment. But in the following case, the effect of closing the cervical rent on the general neurasthenia was too rapid and too direct to admit of question.

CASE IV.—*Neurasthenia cured by trachelorrhaphy.*

Mrs. S. B., mother of several children and wife of a retired physician in a neighboring city, who had found an ample competence in commercial pursuits, called on me late in 1884, for neurasthenic symptoms as marked as I ever saw them. A lithe, active, handsome woman, she had fallen to the necessity of carrying a brandy flask with her wherever she went, to fortify herself against her uncontrollable attacks of faintness and depression. I expected to find some serious uterine lesion, but could discover merely a large laceration of the cervix, with considerable cervical catarrh. As the latter seemed to annoy her, I advised closure of

the laceration, hoping thereafter to act on her neurasthenia by other measures.

The laceration was successfully operated on in January, 1885, and early in October last the lady called on me to exhibit her perfect restoration to health. She had spent the summer on a driving trip with her husband, had grown stout and brown, the brandy bottle had been discarded, and she exultantly proclaimed herself a "healthy woman."

Certainly her appearance did not belie her words !

Now, I am constrained to admit the beneficial influence exerted on the mind in this case by the operation, but I cannot allow that this was the chief factor in the recovery of the patient, for the physical sequence was too marked.

As an illustration of the peculiar relation between an unsuspected uterine disturbance and a remote neurosis I will mention the following case :

CASE V.—*Persistent hemicrania cured permanently by the reposition and retention by a pessary of an unsuspected retroversion of the uterus.*

Miss A. S., forty years, stout, well nourished, was referred to me several years ago by the late Dr. Elsberg for persistent hemicrania, which he had in vain tried to cure. Finally, as her attacks were most severe at the menstrual epochs he suspected possible uterine disease, and sent her to me. Although she complained of absolutely no pelvic sensation, I deemed it my duty to propose a vaginal examination to which she readily consented. To my surprise I found a retroversion of the uterus of the third degree, which I replaced and permanently rectified by inserting a lever pessary. This pessary has now been worn for over four years, with occasional intermissions, and since its introduction the hemicrania has entirely disappeared. I see the lady (who lives several hundred miles from here) two or three times a year in order to watch the pessary, and am, therefore, in a position to know her condition.

In conclusion, I will report an instance of mental disturbance due to uterine displacement, which escaped the notice of several eminent neurologists.

CASE VI.—*Acute retroversion of uterus, followed by dementia, ineffectually treated in an asylum and by various neurologists. Reposition and retention of uterus by supporter speedily followed by permanent restoration to mental health.*

Miss B., nineteen years, slipped down stairs and fell heavily on her seat. Soon after she became morose, irritable, and lost

interest in her surroundings. Sent to a well-known insane asylum in a neighboring city she did not improve, and went the round of celebrated neurologists in our and other cities. In despair her friends finally took her to a notorious female quack who, of course, made a vaginal examination, found a retroversio uteri, replaced and retained the organ, and in three weeks the girl was well. She is now a healthy and happy mother.

I could multiply these instances of the intimate and only too often unsuspected and mysterious relations between the sexual organs and the brain and peripheral nervous system in the female sex almost *ad infinitum*. I could cite cases of apparent paralysis cured by removal of the ovaries (I myself have done such an operation with such a result), or by replacement of a displaced uterus; I could relate instances of mental aberration cured by treatment of the sexual organs, and could draw therefrom most logical deductions and practical suggestions as to the treatment of the female insane, and I could draw out this subject to a length far beyond that originally intended by me or agreeable to my audience. But I will forbear, and take my seat with the hope that this hastily and imperfectly written paper may be generously criticised by my hearers, and may possibly elicit an instructive discussion.